TRENDS IN MEDICARE PARTICIPATION AND ASSIGNMENT RATES, 1984-1987

Final Report

February 5, 1988

NTIS # PB 89-113252

HEALTH ECONOMICS RESEARCH, INC.

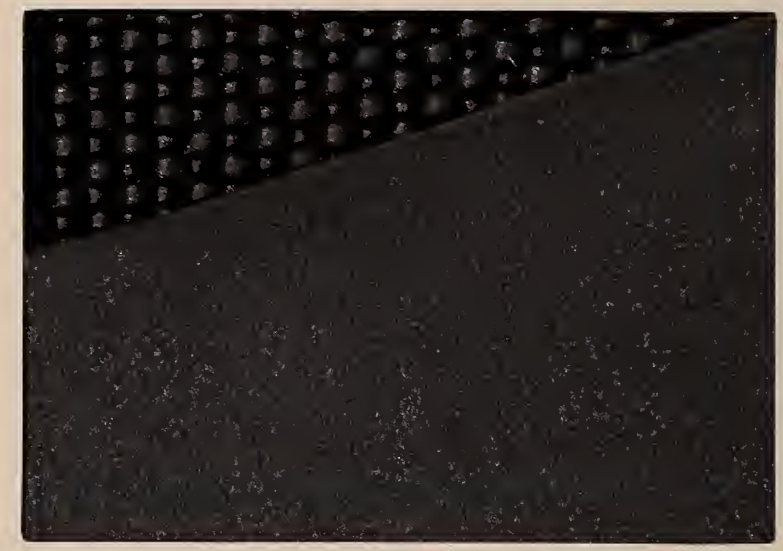

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TABLE OF CONTENTS

		PAGE
1.0	**INTRODUCTION AND SUMMARY**	1-1
	1.1 History of the Medicare Participating Physicians' Program	1-1
	1.2 Summary of Findings	1-3
	1.3 Organization of Report	1-5
2.0	**METHODS**	2-1
	2.1 Data Source	2-1
	2.2 Classification of Participation Decision Patterns	2-3
	2.3 Coding of Open-Ended Questions	2-4
3.0	**TRENDS IN MEDICARE PARTICIPATION RATES, 1984-1987**	3-1
	3.1 Physician Participation Rates and Decision Patterns	3-1
	3.2 Comparability with Other Data Sources	3-5
	3.3 Physicians' Reasons for Signing or not Signing the Participation Agreement	3-9
	3.4 January 1987 Decision	3-17
4.0	**TRENDS IN MEDICARE ASSIGNMENT RATES, 1985-1987**	4-1
	4.1 Method	4-1
	4.2 Assignment Rates by Specialty	4-2
	4.3 Assignment Rates by Decision Pattern	4-4
5.0	**WHO ARE THE DE FACTO PARTICIPANTS?**	5-1
	5.1 Characteristics of De Facto Participants	5-1
	5.2 De Facto Participants' Reasons for Not Signing the Participation Agreement	5-3
	5.3 Comparison of Actual and De Facto Participants	5-5

REFERENCES

APPENDIX A VERBATIM RESPONSE CODES FOR OPEN-ENDED QUESTIONS

TABLE OF TABLES AND EXHIBITS

		PAGE
TABLE 2-1	SCOPE OF SAMPLE	2-2
TABLE 2-2	CLASSIFICATION OF PARTICIPATION DECISION PATTERNS	2-5
TABLE 3-1	PARTICIPATION RATES BY SPECIALTY	3-2
TABLE 3-2	PARTICIPATION DECISION PATTERNS, BY SPECIALTY	3-4
TABLE 3-3	MEDICARE PARTICIPATION RATES BY MAIN PRACTICE ARRANGEMENT	3-5
TABLE 3-4	COMPARISON OF MEDICARE PARTICIPATION RATES FROM THREE DATA SOURCES	3-7
TABLE 3-5	REASONS FOR SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY LEVEL OF IMPORTANCE	3-12
TABLE 3-6	REASONS FOR NOT SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY LEVEL OF IMPORTANCE	3-16
TABLE 3-7	RELATIONSHIP BETWEEN PREVIOUS PARTICIPATION DECISIONS AND THE JANUARY 1987 DECISION	3-20
TABLE 4-1	ASSIGNMENT RATES BY SPECIALTY, 1985-1987	4-3
TABLE 4-2	ASSIGNMENT RATES BY DECISION PATTERN, 1985-1987	4-5
TABLE 5-1	EXTENT OF ASSIGNMENT BY SPECIALTY GROUP AND MEDICARE DEPENDENCE	5-2
TABLE 5-2	REASONS FOR NOT SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY EXTENT OF ASSIGNMENT (Percent stating reason was very important)	5-4
TABLE 5-3	COMPARISON OF ACTUAL AND DE FACTO PARTICIPANTS, BY SPECIALTY GROUP AND MEDICARE DEPENDENCE	5-6
EXHIBIT 3-1	COMPARISON OF UNIVERSE DEFINITIONS AND TARGET POPULATIONS: PHYSICIANS' PRACTICE FOLLOW-UP SURVEY AND HCFA BUREAU OF PROGRAM OPERATIONS CARRIER DATA	3-9

TRENDS IN MEDICARE PARTICIPATION AND ASSIGNMENT RATES, 1984-1987

1.0 INTRODUCTION AND SUMMARY

1.1 History of the Medicare Participating Physicians' Program

The Deficit Reduction Act of 1984 (DEFRA) created a Participating Physicians' Program under Part B of Medicare. Physicians who signed the Participation Agreement would accept 100 percent of Medicare cases on assignment. Those who chose not to participate would still be able to decide on a case-by-case basis whether to accept the assigned amount from Medicare (as payment in full), or whether to bill patients directly for their actual fee. The major incentive for participating was an update in the charge profile for participants, but not for non-participants, at the end of the fee freeze.

The initial participation period was for the fiscal year beginning October 1, 1984. Congress extended the participation program and the fee freeze, instituting a second sign-up period for the fiscal year beginning October 1, 1985. When the freeze on prevailing charges for participating physicians was lifted, a third participation decision was made as of May 1, 1986. Finally, under the Omnibus Budget Reconciliation Act of 1986 (OBRA) a fourth decision period was provided. Based on a complex array of participation incentives included under OBRA, physicians were required to decide by January 1, 1987 whether or not to sign the Participation Agreement.

First, the update in the prevailing charge levels for non-participants was only 96 percent of the prevailing charge for participants. Second, non-participants have been limited in their actual charge levels (known as the maximum allowable actual charge), based on a formula that compares the lower of (1) the physicians' 1984 base-period charge or (2) the 1986 average actual charge, to the 1987 prevailing charge for non-participating physicians. The actual charge limits are calculated for each procedure or service the physician performs. Beginning October 1, 1987, non-participants must notify beneficiaries of the estimated actual charge for elective surgery of $500 or more; the estimated approved charge; the amount by which the actual charge exceeds the approved charge; and the amount of coinsurance. This provision is designed to provide the beneficiary with sufficient information on potential liability for elective surgical procedures.

Other participation incentives include prompter payment of participants' claims; listing in a directory of participating physicians; notices about the participation program to beneficiaries submitting unassigned claims;

requirement for hospital officials to inform patients of physician participation status when making hospital referrals and to identify a participating physician, where possible; toll-free telephone lines maintained by the carriers to provide names of participating physicians; and emblems of participation to display in the physician's office.

The 1987 Physicians' Practice Follow-up Survey provides a unique opportunity to study the impact of these sweeping changes in physician participation and assignment incentives during the mid-1980s. Physicians participating in the 1983 Physicians' Practice Costs and Income Survey were resurveyed during the first six months of 1987 on a variety of topics, including their participation decisions in each of the four sign-up periods. In addition, they were asked about their reasons for signing or not signing. Also, non-participating physicians were asked what percent of their Medicare caseload is currently accepted on assignment.

This report has five objectives:

- Identify participation rates and participation patterns over the four sign-up periods.
- Describe the motivations behind physicians' participation decisions.
- Highlight the impact of the new incentives introduced with the January 1987 decision.
- Examine trends in assignment rates since the introduction of the participation program.
- Describe the characteristics of one subgroup of non-participants, known as de facto participants because they accept all cases on assignment but they have not signed the participation agreement. Who are the de facto participants and why do they refuse to sign the agreement?

1.2 Summary of Findings

This report examines trends in Medicare participation across the four sign-up periods: October 1984, October 1985, May 1986, and January 1987. The 1987 Physicians' Practice Follow-up Survey is a unique data source for this analysis because it tracks the participation decisions for a panel of physicians across the four time periods. Physicians with any Medicare patients who were able to report their participation decision for all four time periods are included.

Overall, participation rates dropped slightly from 37 percent in October 1984 to 34 percent in October 1985, presumably reflecting physicians' expectation that the fee freeze would be extended beyond the original 15-month period. In May 1986 this rate increased to 36 percent, in part due to the

incentive of differential charge updates to participating physicians. By January 1987, nearly 39 percent of physicians had signed participation agreements in response to a wide range of incentives as discussed above. (However, none of these differences were found to be statistically significant.)

Most specialties followed this pattern so the relative differences in participation rates remained relatively constant, with one notable exception. Participation rates among obstetrician/gynecologists steadily increased over the four time periods from 36 percent in October 1984 to 45 percent by January 1987.

Most physicians were consistent in their decision across the first three time periods:

- 30 percent of all physicians signed in October 1984 as well as the subsequent two time periods. The two most important factors in their decision were the advantages to their patients and that they already accepted most cases on assignment so there would be no particular disadvantage to the physician in signing.

- 57 percent refused to sign in all three time periods. Nearly all of these physicians believe that physicians should set their own fees. This group also preferred to leave open the option of balance billing.

- Only 13 percent changed their decision, including about 7 percent who changed from signers to non-signers, about 6 percent who changed from non-signers to signers and less than 1 percent who changed from signers to non-signers and then back to signers in May 1986. Financial incentives and disincentives were often important reasons for these physicians who changed their mind. Non-participants decided to sign the agreement to obtain an increase in the amount Medicare would pay after the freeze was lifted. Physicians deciding not to renew the agreement felt the most important reason was the perceived government double cross when the fee freeze was extended.

No dramatic changes were found with the January 1987 participation decision. From May 1986 to January 1987, only 5 percent of non-signers became signers and 2 percent of signers decided not to renew the agreement. The two most common reasons cited by previous non-participants for signing the agreement in January 1987 were to reduce administrative burden and because physicians "felt forced" by the government. Among those who changed from signers to non-signers, the most important factor was low or unpredictable payments, followed by a change in practice situation (e.g., retirement, new employer).

Participation rates clearly vary by type of employment arrangement. For example, in January 1987, participation rates of self-employed physicians (37 percent) were about 20 percentage points lower than those employed by

hospitals or universities (57 percent) and about 10 percentage points lower than those employed by an HMO or clinic (46 percent) or another physician or corporation (44 percent).

Assignment rates were compared between 1985 and 1987 to determine whether the participation program has had a substantial impact on assignment among participants as well as non-participants. Overall, assignment rates increased about 2 percent, from 53.0 percent to 53.9 percent, although this was not a significant change. These figures are based on data from the original 1983 Physicians' Practice Costs and Income Survey and the 1987 Physicians' Practice Follow-up Survey, and are based on physicians who were self-employed in the original survey. The assignment rates reflect the percent of current Medicare caseloads accepted on assignment and are not weighted by covered charges or Medicare volumes. Surgeons had the highest assignment rates and physicians in three surgical specialties (ophthalmology, urology, and obstetrics/gynecology) had the highest rates of increase in assigned caseloads. Only general practitioners had a large decline, probably due in part to a high proportion dropping out of the participating physician program.

Of particular interest is the impact of the participation program on non-participants' assignment rates. Has the threat of competition from participants forced them to increase their assignment rates? From 1985 to 1987, non-participating physicians significantly increased their assignment rates from 24 percent to nearly 30 percent, a 24 percent gain.

We highlighted one group of non-participating physicians, known as the de facto participants because they accept all cases on assignment even though they have not signed the participation agreement. About 6 percent of non-participants are de facto participants. Surgeons are disproportionately represented among de facto participants compared to medical specialists and general/family practitioners. This may reflect a desire to keep their billing options open, rather than be locked into the participation agreement. Physicians with small Medicare caseloads (less than 10 percent of patients) also account for a higher share of de facto participants. In general, what seems to be dominating their motivation for not signing is a philosophical opposition to the terms of the participation agreement, particularly the belief that physicians should set their own fees.

1.3 Organization of Report

The remainder of this report is organized in four chapters. Chapter 2.0 describes the data base and sample included in this analysis as well as the methods used to classify physicians by their participation decision and to

code open-ended questions. Chapter 3.0 focuses on trends in physician participation rates from 1984 to 1987, including the frequency of the various participation patterns, physicians' reasons for signing or not signing (or changing their decision), and physicians' response to the incentives introduced with the January 1987 decision. In addition, we compare participation rates from the follow-up survey to other data sources, including HCFA carrier data. Chapter 4.0 compares assignment rates in 1985 and 1987 by specialty and decision pattern. Finally, Chapter 5.0 describes the de facto participants, an interesting group of non-participants who accept all cases on assignment.

2.0 METHODS

2.1 Data Source

This analysis is based on data from the Physicians' Practice Follow-up Survey (PPFS) conducted by NORC during the first six months of 1987. Physicians participating in the 1984-85 Physicians' Practice Costs and Income Survey (PPCIS) were asked follow-up questions on their practice arrangements, malpractice coverage, and Medicare participation. In addition, the interview included questions on the time and complexity involved in performing 10-15 selected medical or surgical procedures related to the particular specialty. Finally, surgeons were asked about the billing practices and office visit patterns associated with several surgical procedures.

The 1984-85 PPCIS included 4,729 physicians, with a response rate of 67.6 percent. The Follow-up Survey excluded physicians specializing in pediatrics, pathology, psychiatry, and "all other specialties" (except neurologists were included).* The sample for the follow-up survey consisted of 3,554 physicians, of which 2,499 physicians (74.2 percent) completed the interview. The completion rate ranged from 62.5 percent among cardiovascular/thoracic surgeons to 83.0 percent among neurologists. Statistical weights used in the analysis included adjustments for non-response in the original and follow-up surveys, as well as the disproportionate probability of selection.

This report presents trends in Medicare participation rates for the four sign-up periods: October 1984, October 1985, May 1986, and January 1987. This analysis is based on 2,334 physicians with Medicare patients who were able to report participation decisions for all four time periods. Table 2-1 presents sample sizes by specialty. Because of the small number of neurologists in our sample (n=34), estimates are not presented for this specialty separately but are included in the totals for all physicians.

Specifically physicians were asked:

> In 1984, Congress enacted legislation concerning Medicare patients and assignment of benefits. Physicians were given an opportunity to sign an agreement to accept assignment of benefits for <u>all</u> their Medicare patients.
>
> A. <u>IF PPA STATUS 1984 "MISSING"</u>:
>
> Did you sign the agreement in October, 1984?
>
> Yes.....1
> No.....2

*This residual category includes physicians specializing in emergency medicine, rehabilitation medicine, occupational medicine, and general preventive medicine.

TABLE 2-1

SCOPE OF SAMPLE

Specialty	Number of physicians in sample[a]	Number of physicians in this analysis[b]
TOTAL	2,499	2,334
General practice	174	164
Family practice	334	310
Internal medicine	318	297
Cardiology	89	84
Other medical specialties	194	183
General surgery	176	168
Orthopedic surgery	104	100
Ophthalmology	104	102
Urology	125	123
Obstetrics/gynecology	205	175
Other surgical specialties	134	129
Anesthesiology	256	236
Radiology	250	229
Neurology[c]	36	34

[a]Reflects the number of physicians that participated in the Physicians' Practice Follow-up Survey.

[b]Reflects the number of physicians with Medicare patients who were able to report their participation decisions in all four time periods.

[c]Due to the small sample size, separate estimates have not been made for neurologists, but these physicians are included in the totals for all specialties.

Source: 1987 Physicians' Practice Follow-up Survey.

B. IF PPA STATUS 1984 "SIGNED" OR "DID NOT SIGN":
During the previous interview you reported that you (signed/did not sign) the agreement in October 1984. Is that correct?

Yes.....1
No.....2

Since that initial decision in October, 1984, you have had at least two other opportunities to sign the Medicare Participating Physicians' Agreement.

Did you sign the Agreement for the period beginning October, 1985?

Yes.....1
No.....2

Did you sign in May, 1986?

Yes.....1
No.....2

You recently had another opportunity to sign the Participating Physicians' Agreement.

Did you sign for the period beginning January, 1987?

Yes.....1
No.....2

Based on their participation decision patterns, physicians were asked a series of open- and close-ended questions concerning their reasons for signing, not signing, or changing their decision. Section 2.2 describes the classification of physicians by decision pattern. Section 2.3 describes the coding of open-ended questions.

Non-participating physicians were asked "what percent of your current Medicare caseload is accepted on assignment." These data are compared to assignment rates gathered in the initial PPCIS. Chapter 4.0 describes in greater detail the methods used to compare assignment rates for 1985 versus 1987.

2.2 Classification of Participation Decision Patterns

Physicians were classified into five different groups depending upon their participation in each of the first three time periods: October 1984, October 1985, and May 1986. Physicians either signed throughout; did not sign throughout; changed from a signer to a non-signer; changed from a non-signer to signer; or changed from a signer to a non-signer and then signed again in May 1986.

Participation status in 1984 was determined by asking physicians if the response we received in the original PPCIS was correct. Because only self-employed physicians were asked about their participation status in the 1983 survey, the follow-up survey asked physicians who were employed at the time of the original survey whether or not they signed the agreement in October 1984. In addition, physicians who were unable to report their 1984 participation decision in the PPCIS were asked to recollect if they had signed in 1984. Participation status in 1985 and 1986 were directly asked in the follow-up survey.

Of the 2,499 physicians included in the sample, we were unable to classify 102 physicians (4 percent) based on their decision pattern because of missing data. About one-third of these physicians were missing participation status for all time periods. One-fourth had no values for two of the time periods. An additional 63 physicians with no Medicare patients are excluded.

Table 2-2 shows the frequency of the five decision patterns and the criteria used to classify physicians. The largest group by far is the non-signers throughout. Physicians who changed from signers to non-signers followed one of two patterns: (1) signing in 1984 and 1985 and refusing to renew in 1986; or (2) signing initially in 1984 and then dropping out of the participating physicians' program in 1985 and 1986. The opposite two patterns apply to physicians who changed from non-signers to signers. A small number of physicians changed from a signer to a non-signer after one year in the program and then signed again in May 1986.

2.3 Coding of Open-Ended Questions

Based on their participation decisions at three points in time (October 1984, October 1985, May 1986), respondents were directed into one of five questionnaire paths. Physicians were asked to rate the importance of a series of close-ended reasons for their decision. In addition, they were asked whether there were "any other reasons that were very important in their decision." Given the unpredictable motivations of the physicians who changed their decision twice, no specific reasons were given; instead the responses were entirely open-ended.

Close-ended questions were formulated on the basis of experience gained during the 1983 survey in designing and utilizing a coding scheme for open-ended responses concerning physicians' reasons for signing or not signing the agreement. In addition, the close-ended questions incorporate substantive background knowledge about changes in the participation program.

TABLE 2-2

CLASSIFICATION OF PARTICIPATION DECISION PATTERNS

	Number of Physicians[a]		October 1984	October 1985	May 1986
Signer throughout	701		X	X	X
Non-signer throughout	1,343		--	--	--
Signer to non-signer	146		X	X	--
		or	X	--	--
Non-signer to signer	127		--	X	X
		or	--	--	X
Signer/non-signer/signer	17		X	--	X
TOTAL	2,334				

X = signed participation agreement.

-- = did not sign participation agreement.

[a]Includes physicians with any Medicare patients who were able to report their participation decision for the first three sign-up periods.

Source: 1987 Physicians' Practice Follow-up Survey.

In a few cases, the verbatim response was an exact restatement of one of the close-ended questions. For example, one physician remarked that he/she signed "to reduce paperwork." Because this physician also responded to the close-ended question "to reduce paperwork and administrative burden," a separate code for the open-ended response was unnecessary. However, in cases where physicians indicated that a specific reason was not important but gave an "other" reason that was very similar to the specified reason, a separate code was entered. This generally suggests that the physician did not understand the specified reason (for example, the term "balance bill" may not be familiar to the respondent).

Many of the "other" reasons given by both signers and non-signers echo a single theme: philosophical agreement with or opposition to the program. This dimension was intentionally omitted from the close-ended questions but has been captured in the coding of the open-ended responses.

Appendix A displays the categories of the open-ended coding schemes for four of the participation decision patterns together with examples of responses in each category: signers throughout (Table A-1); non-signers throughout (Table A-2); signers to non-signers (Table A-3); and non-signers to signers (Table A-4). The coding schemes for signers throughout and non-signers to signers are identical as are the coding schemes for non-signers throughout and signers to non-signers. However, separate examples are presented for each decision pattern.

Very few physicians signed initially, then did not sign, and then signed again. Due to small sample sizes as well as problems in interpreting their responses, the open-ended responses have not been coded. These responses are discussed, however, in Section 3.2.

Physicians who changed their decision from May 1986 to January 1987 were also asked an open-ended question concerning their motivations in changing their decision. The verbatim response codes used to classify these open-ended remarks (together with examples) are presented in Table A-5.

3.0 TRENDS IN MEDICARE PARTICIPATION RATES, 1984-1987

Physicians have been given four opportunities to sign the Physician Participation Agreement: October 1984, October 1985, May 1986, and January 1987.* This chapter presents the participation rates for each of these four sign-up periods for physicians overall, by specialty, and by practice arrangement. We also present the frequency of the five possible decision patterns for the first three time periods: signing throughout; not signing throughout; changing from a signer to a non-signer; changing from a non-signer to a signer; or changing from a signer to a non-signer and then signing again in May 1986. As discussed in Section 2.2, participation status was not known for 102 physicians and these physicians have been excluded from our analysis. Physicians treating no Medicare patients were also excluded. This chapter also examines physicians' reasons for signing or not signing or changing their decision. Finally, the January 1987 decision is examined separately with respect to previous decision patterns.

3.1 Physician Participation Rates and Decision Patterns

Table 3-1 presents the participation rates for each decision point by specialty. Overall, participation rates decreased slightly between the first two time periods and then slowly increased again. The participation rate for all physicians was 37 percent in 1984 and then dropped to 34 percent in 1985, probably due in part to physicians' dissatisfaction with the extension of the fee freeze beyond the original 15-month period. In 1986 this rate increased to 36 percent and in January of 1987 nearly 39 percent of all physicians signed the participation agreement.** Section 3.2 compares participation rates from the Follow-up Survey with those from the original Physicians' Practice Costs and Income Survey and with HCFA Carrier Data (Burney and Paradise, 1987).

Most specialties followed the same pattern so the relative differences in participation rates remained constant across time periods. Obstetrician/gynecologists are a notable exception. Their participation rates steadily increased over the four time periods from almost 36 percent in October 1984 to 45 percent in January 1987. Whereas in October 1984 their

*As of this writing, a fifth sign-up period is scheduled to occur by April 1, 1988.

**However, none of these differences were found to be statistically significant, based on a two-tailed t-test, at the 0.05 level.

TABLE 3-1

PARTICIPATION RATES BY SPECIALTY[a]

	October 1984	October 1985	May 1986	January 1987
ALL PHYSICIANS	**37.0%**	**34.3%**	**36.1%**	**38.6%**
General Practice	33.5	27.7	29.3	31.2
Family Practice	31.1	25.8	27.5	27.6
Internal Medicine	38.6	31.9	35.6	39.1
Cardiology	45.3	44.9	43.6	48.5
Other Medical Specialties	41.8	36.2	36.8	42.9
General Surgery	43.8	42.4	45.2	46.8
Orthopedic Surgery	39.6	38.9	39.7	42.8
Ophthalmology	29.0	26.1	27.3	33.0
Urology	32.4	31.7	35.3	38.3
Obstetrics/Gynecology	35.6	39.2	42.5	45.0
Other Surgical Specialties	31.6	32.2	31.6	34.1
Anesthesiology	26.2	23.1	23.8	24.6
Radiology	51.5	53.9	56.8	56.6

[a]Only includes physicians for whom participation status was known for every decision point, and who treated Medicare patients.

Source: 1987 Physician's Practice Follow-up Survey.

participation rate was slightly below the average for all physicians, in 1987 their rate was well above the average (although this difference was not found to be statistically significant).

The specialties with the highest participation rates in all four time periods were radiologists, cardiologists, and general surgeons. In January 1987 their rates were 57 percent, 49 percent, and 47 percent respectively. Anesthesiologists remain the specialty with the lowest participation rates, consistently 10 to 14 percentage points lower than the average participation rates for all physicians.

Physicians were categorized into five groups based on their participation decision in the first three time periods. The January 1987 decision was considered separately. Table 3-2 presents the frequency of decision patterns by specialty. Most physicians were consistent in their decisions: what they decided in October 1984 tended to be their decision for the next two time periods as well. For example, 30 percent of all physicians decided to sign the participation agreement in 1984 and continued to sign in 1985 and 1986. Another 57 percent did not sign the agreement at each decision point. The remaining physicians (13 percent) changed their decision in one or more time periods, including almost 7 percent who changed from signers to non-signers and about 6 percent who changed from non-signers to signers. (This includes physicians who changed their decision as of October 1985 <u>or</u> May 1986.) Less than one percent of physicians changed their decision at each of the first three points.

Examining the decision patterns across specialties, radiologists were by far the most likely to sign throughout. Anesthesiologists and ophthalmologists were most likely to be classified as non-signers throughout (71 percent and 67 percent, respectively). Obstetrician/gynecologists were most likely to change from non-signers to signers (10 percent), which explains their steadily increasing participation rates shown in Table 3-1.

Participation rates for each of the four decision points are presented by the physicians' main employment or practice setting in Table 3-3. Participation rates varied considerably by practice arrangement. Physicians employed by hospitals or universities have participation rates at about 56 to 57 percent, nearly 20 percentage points higher than their self-employed colleagues across all four sign-up periods. Physicians practicing in a clinic or HMO increased their participation slightly from 40 percent in October 1984 to nearly 46 percent in January 1987. Participation rates for physicians employed by another physician or corporation remained fairly constant, at about 40 percent in the first three periods and 44 percent in January 1987.

TABLE 3-2

PARTICIPATION DECISION PATTERNS, BY SPECIALTY[a]

	Signer	Non-Signer	Signer to Non-Signer	Non-Signer to Signer	Signer/ Non-signer/ Signer
ALL PHYSICIANS	**29.9%**	**57.4%**	**6.5%**	**5.6%**	**0.7%**
General Practice	21.6	60.4	10.4	6.2	1.6
Family Practice	21.1	62.9	9.7	6.0	0.4
Internal Medicine	30.2	56.7	7.7	4.7	0.7
Cardiology	37.3	49.4	6.9	5.3	1.1
Other Medical Specialties	33.3	55.3	7.9	2.9	0.6
General Surgery	37.9	49.7	5.2	6.5	0.8
Orthopedic Surgery	32.9	54.4	5.9	6.0	0.9
Ophthalmology	22.3	67.2	5.5	3.8	1.1
Urology	27.6	61.6	3.0	6.0	1.8
Obstetrics/Gynecology	32.5	54.4	3.0	10.0	0.0
Other Surgical Specialties	27.5	64.3	4.1	4.2	0.0
Anesthesiology	20.6	71.0	5.2	2.8	0.4
Radiology	47.3	39.8	3.4	8.7	0.8

[a]Based on participation decisions in October 1984, October 1985, and May 1986. Rows sum to 100 percent.

Source: 1987 Physicians' Practice Follow-up Survey.

TABLE 3-3

MEDICARE PARTICIPATION RATES BY MAIN PRACTICE ARRANGEMENT[a]

	October 1984	October 1985	May 1986	January 1987
Self Employed	**35.3%**	**32.1%**	**33.0%**	**36.6%**
Employed by:				
Hospital or University	55.6	55.8	56.8	56.9
Clinic or HMO	40.3	40.6	44.0	45.8
Another Physician or Corporation	41.3	38.8	40.4	44.3

[a]Based on main practice arrangement at time of follow-up interview.

Source: 1987 Physicians' Practice Follow-up Survey.

3.2 Comparability with Other Data Sources

The participation rates obtained in the Physicians' Practice Follow-up Survey can be compared to two other data sources. First, we compare the rates obtained in the initial Physicians' Practice Costs and Income Survey (PPCIS) to those obtained in the Follow-up Survey. Second, we compare the rates from the Follow-up Survey to HCFA carrier data, as published in Burney and Paradise (1987). Table 3-4 displays participation rates from the three sources.

3.2.1 1984-85 Physicians' Practice Costs and Income Survey

The initial PPCIS estimated a participation rate of 33.2 percent in October 1984, compared to a rate of 37.0 percent from the Follow-up Survey. The initial estimate included only self-employed physicians with any Medicare patients. A more comparable figure from the Follow-up Survey is 35.3 percent, also reflecting the participation rate for self-employed physicians with any Medicare patients. We constructed 95 percent confidence intervals around the mean participation rates. The estimate from the initial PPCIS for self-employed physicians (33.2%) lies just inside the confidence interval for the estimate from the follow-up survey (33.2% to 37.5%), suggesting that the two sample estimates are not statistically different.

Differences between the two estimates may occur for several reasons. First, physicians were given an opportunity to update information reported in the initial interview. Some small percentage (about 2.5 percent) reported that the earlier data were incorrect. Second, designation of employment arrangement is based on the physician's status at the time of interview. Physicians are not always clear on whether to consider themselves self-employed versus employed (e.g., by corporation) and several internal inconsistencies have been noted between the initial PPCIS and the Follow-up Survey. Third, several specialties have been omitted from the Follow-up Survey: pathologists, psychiatrists, pediatricians, and the "all other specialties," principally emergency medicine specialists (with the exception of neurologists who are included here).

3.2.2 HCFA Carrier Data

Next, we compare participation rates from the Follow-up Survey with those from HCFA carrier data. Burney and Paradise (1987) recently published physician participation rates for the four participation periods. They report that 30 percent of physicians signed agreements in October 1984, falling to 28 percent in the two subsequent periods and rising to nearly 31 percent in

TABLE 3-4

COMPARISON OF MEDICARE PARTICIPATION RATES FROM THREE DATA SOURCES[a]

Data Source	October 1984	October 1985	May 1986	January 1987
1987 Physicians' Practice Follow-up Survey[b]				
All physicians	37.0%	34.3%	36.1%	38.6%
Self-employed physicians	35.3	32.1	33.0	36.6
1983 Physicians' Practice Costs and Income Survey (self-employed physicians only)	33.2[c]	NA	NA	NA
HCFA Carrier Data				
Percent of physicians	30.4	28.4	28.3	30.6
Percent of covered charges	36.0	36.3	38.7	43.7

NA = Not available

[a]See text for description of data sources.

[b]The 95 percent confidence interval around these participation rates is plus or minus 2 percentage points (e.g., 35.0% to 39.0% for all physicians in October 1984).

[c]The 95 percent confidence interval is plus or minus 0.9 percentage points (i.e., 32.3% to 34.1%).

Sources:
1. 1987 Physicians' Practice Follow-up Survey.
2. Rosenbach, Hurdle, and Cromwell (1985).
3. Burney and Paradise (1987).

January 1987. When weighted by covered charges, the participation rates are consistently higher -- ranging from 36 percent for fiscal year 1985, to nearly 44 percent for the first quarter of 1987 (the latest period for which data are available).

The HCFA carrier data and the Follow-up Survey estimates differ by about six to eight percentage points in each decision period, beyond the 95 percent confidence intervals around the means from the Follow-up Survey. These differentials may be due to eligibility criteria for the Follow-up Survey. Exhibit 3-1 displays the eligibility criteria for the Follow-up Survey and the corresponding status for the HCFA carrier data.

The HCFA carrier data represent a counting of the universe of all physicians billing Medicare for at least one service in the previous year while the Follow-up Survey includes a sample of 2,334 physicians treating Medicare patients. Non-response bias and other sources of sampling error could also account for some of the difference. In addition, the survey data reflect participation by individual physicians whereas the carrier data are based on provider billing number. (Physician groups are assigned a single billing number.) Data collection methods also vary: the Follow-up Survey relies on physician recall and knowledge of their (or their employer's) participation decision, whereas Burney and Paradise base their estimates on carrier reports of the number of signed participation agreements.

The definition of provider type is strictly limited in the Follow-up Survey, including only Doctors of Medicine (M.D.s). The HCFA rates are based on M.D.s, Doctors of Osteopathy (D.O.s), and other patient care providers, noteably audiologists, psychologists, physical therapists, chiropractors, podiatrists, optometrists, and oral surgeons.

The sampling design of the initial 1984-85 Physicians' Practice Costs and Income Survey as well as the 1987 Follow-up Survey place strict limitations on physician eligibility in terms of level of activity. A physician must be actively engaged in patient care activity at least 20 hours per week at the time of interview and, furthermore, must have engaged in patient care activity at least 20 hours a week during some part of calendar year 1983 (initial survey) and for six month of 1986 (Follow-up Survey). The only restriction placed on eligibility for the HCFA carrier data was that the provider must have filed at least one Medicare claim during the year. Thus, the HCFA carrier data include some physicians that would be excluded from the PPCIS on the basis of patient care activity level. In addition, "new physicians" (that is, entering practice since 1983) would not be eligible for the Follow-up Survey but would be eligible to have a Medicare provider number and thus, to sign the participation agreement.

The geographic locations are essentially the same -- the 50 United States and the District of Columbia -- except the HCFA data set also includes physicians/claims from Puerto Rico and the Virgin Islands.

EXHIBIT 3-1

COMPARISON OF UNIVERSE DEFINITIONS AND TARGET POPULATIONS: PHYSICIANS' PRACTICE FOLLOW-UP SURVEY AND HCFA BUREAU OF PROGRAM OPERATIONS CARRIER DATA

Eligibility Criteria	Physicians' Practice Follow-up Survey	HCFA Carrier Data*
Sampling Frame/ Universe	Participants in the 1984-85 Physicians' Practice Costs and Income Survey (PPCIS); Initial PPCIS sample drawn from AMA Physician Master File	All physicians with a provider ID number who filed a claim in previous year
INCLUSIONS:		
Type of provider	M.D.s (excludes those not classified by specialty)	M.D.s, D.O.s, other patient care providers (e.g., psychologists, chiropractors, optometrists)
Level of activity	Must be actively engaged in patient care activity at least 20 hours per week; Also, must have engaged in at least 20 hours patient care a week during some part of 1983 and for six months of 1986	No requirements (except a Medicare claim must have been submitted within previous year)
Geographic location	50 states, D.C.	50 states, D.C., Puerto Rico, Virgin Islands
EXCLUSIONS:		
Employment restrictions	• Federal government employees** • State/local government employees unless providing at least 20 hours patient care per week • Resident, research fellows • Full-time faculty members unless also providing 20 hours patient care per week	Anyone with a provider ID number who filed a Medicare claim in previous year is included (residents, research fellows, federal employees, state/local government employees, and full-time faculty would tend to be excluded)***
Specialty restrictions	Pediatricians, pathologists, psychiatrists, "all other" specialties (except neurologists are included)	None
Other restrictions	Physicians treating Medicare patients who reported participation decision for first three decision periods	None

M.D. -- Doctor of Medicine
D.O. -- Doctor of Osteopathy

*As published in Burney and Paradise (1987).

**These employment restrictions apply to eligibility for the initial PPCIS only.

***Institutional employees are included in Medicare Part A billings rather than Part B (fee-for-service) billings.

The initial PPCIS imposed strict employment setting limits on physician eligibility. Physicians responding to the PPCIS could not be employed by the federal government; by a state or local government unless patient care is provided at least 20 hours per week; could not be a resident or research fellow; and could not be a full-time faculty member unless providing patient care at least 20 hours per week. (These restrictions were waived in the Follow-up Survey for respondents who had changed practice settings.) These limitations would not be expected to result in substantial differences between the Follow-up Survey and the HCFA carrier data, since government employees tend not to have Medicare provider ID numbers. Similarly, residents and research fellows are salaried and would not be eligible for separate Medicare ID numbers; however, if these physicians "moonlight" and have billing numbers, they would be included in the HCFA carrier data. (This situation is relatively rare.)

The Follow-up Survey excludes physicians in several specialties, pediatrics, pathology, psychiatry, and "all other" specialties* (except neurologists are included). Pathologists and emergency medicine specialists, in particular, had very high participation rates in the initial participation period and pediatricians and psychiatrists had low participation rates and Medicare caseloads.** No specialty restrictions were imposed by the HCFA carrier data.

Finally, the Follow-up Survey estimates are based on physicians treating Medicare patients who were able to report their participation decisions for the first three time periods. No such restrictions are present in the HCFA carrier data.

The participation rates from the Follow-up Survey are not weighted for Medicare volumes. Nevertheless, the rates are closer to the weighted participation rates produced by Burney and Paradise. Whereas the Follow-up Survey estimates a participation rate of 37 percent in October 1984, Burney and Paradise indicate that participants' charges were 36 percent of total charges. For the fourth participation period, rates of 39 percent and 44 percent were obtained from the two sources, respectively. Burney and Paradise suggest:

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*This residual category includes physicians specializing in emergency medicine, rehabilitation medicine, occupational medicine, and general preventive medicine.

**Refer to Rosenbach, Hurdle, and Cromwell (1985) and Rosenbach, Harrow, and Cromwell (1986) for detailed information on participation rates in October 1984.

The 43.7 percent should be interpreted cautiously, however, in light of a possible seasonal effect; the rate reflects only those claims processed during the first quarter of 1987. Beneficiaries frequently wait until they meet the $75 deductible before submitting unassigned claims, while physicians submit assigned claims more quickly. Thus, the share of total covered charges accounted for by participating physicians in the first quarter may overstate the rate for the entire year.

3.3 Physicians' Reasons for Signing or not Signing the Participation Agreement

Based on responses to the 1984-85 survey (and taking into account program changes enacted by Congress), physicians were asked to rate the importance of a list of specific reasons in their decision to sign or not to sign the participation agreement (or to change their decision). Table 3-5 indicates the importance of these reasons for physicians who either signed throughout the first three time periods or who changed from a non-signer to a signer.

Among physicians signing throughout the three time periods, two factors above all others motivated physicians' decisions. First, 65 percent cited the advantages to patients as a very important reason and 50 percent indicated they already accepted most cases on assignment so there would be no particular disadvantage to the physician in signing. Surprisingly, the "economic" reasons were considered relatively unimportant, including:

- increase amount Medicare pays after fee freeze (20 percent considered this very important);
- maintain same charges for Medicare and non-Medicare patients during freeze (18 percent);
- obtain the differential payment after the fee freeze is lifted (18 percent); and
- reduce paperwork and administrative burden (18 percent).

It would appear also that colleagues were not influential in the decision to sign, or at least not in retrospect. Only 14 percent of physicians considered their colleagues' suggestions a very important factor. Similarly, only 14 percent indicated that the prospect of increased Medicare patient load was an important factor, suggesting that they signed because of the advantages to their current patient load rather than to attract new patients.

Physicians who reported that increasing their Medicare patient load was somewhat or very important were asked whether their Medicare patient load had increased, decreased, or stayed the same since signing the agreement in

TABLE 3-5

REASONS FOR SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY LEVEL OF IMPORTANCE

	Very Important	Somewhat Important	Not Important
Signers Throughout			
Colleagues suggested that they sign	13.6%	15.9%	70.4%
Already accepted most cases on assignment	49.6	31.9	18.4
Increase patient load	13.8	22.5	63.7
Reduce paperwork and administrative burden	17.6	28.0	54.5
Same charges for Medicare and non-Medicare patients during freeze	18.4	30.3	51.4
Increase amount Medicare pays after freeze	19.7	31.4	49.0
Obtain differential payment after freeze	17.6	32.7	49.7
Advantageous to patients	65.1	23.9	11.1
Non-Signer to Signer			
Colleagues suggested that they sign	7.5%	13.0%	79.5%
Already accepted most cases on assignment	36.3	33.6	30.2
Increase patient load	12.1	16.3	71.6
Reduce paperwork and administrative burden	17.7	32.4	49.8
Same charges for Medicare and non-Medicare patients during freeze	15.0	37.2	47.8
Increase amount Medicare pays after freeze	47.1	32.6	20.3
Obtain differential payment after freeze	15.9	31.5	52.6
Advantageous to patients	24.3	28.1	47.6

Source: 1987 Physicians' Practice Follow-up Survey.

October 1984. Three-fourths of physicians who signed throughout reported that their Medicare caseload stayed the same. We compared the physicians' response to this question with estimates of their relative Medicare caseloads from the initial PPCIS and the Follow-up Surveys. Interestingly, these two measures of the change in Medicare caseloads yield different results. Although physicians were very likely to state that their Medicare caseload stayed the same when asked for their general impressions, the more objective measure (comparing figures from the two surveys) often indicated that their caseload had either increased or decreased.*

There are several possible explanations for this difference. First, when physicians were asked if their Medicare caseload had increased, decreased, or stayed the same, their response was based largely on their perception of this change. Second, their response may reflect the impact on the absolute size of their caseload, while the more objective measure provides an estimate of changes in their relative Medicare caseload. (In other words, if their overall patient load had decreased while their absolute Medicare patient load stayed the same, then their relative Medicare caseload would have increased.) Third, the 1983 and 1986 estimates may not be entirely comparable due to methodological differences in questionnaire design. In the initial survey, physicians were asked to allocate their entire patient load by primary payor (e.g., Medicaid, Medicare, Blue Cross/Blue Shield), and to reconcile any discrepancies if the total did not equal 100 percent. In 1986, physicians were asked only about their Medicare caseload with no opportunity to reconcile over- or underestimates.

The bottom panel of Table 3-5 indicates the factors influencing physicians who changed their initial decision not to sign the agreement and who signed in one of the two subsequent periods. By far the most important factor motivating their change was to obtain an increase in the amount Medicare would pay after the fee freeze was lifted: 47 percent of non-signers to signers felt this was very important and another 33 percent felt this was somewhat important. Second in order of importance was their practice of already accepting most cases on assignment (36 percent considered this very important). Presumably these physicians weighed the costs and benefits of signing in light of their assignment behavior and decided that the participation agreement would offer no particular disadvantage. Compared to the physicians who signed throughout, physicians who signed in a later time period were motivated less by the perceived advantages to their patients.

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*We used a variety of thresholds to define whether Medicare caseload had increased or decreased. The results are quite insensitive to the threshold.

Physicians who signed throughout and who changed from non-signers to signers were asked if there were any other reasons that were very important in their decision to sign the participation agreement.* Thirty percent of signers throughout and 55 percent of non-signers to signers mentioned other reasons (data not shown). Both signers throughout and non-signers to signers frequently mentioned general altruistic reasons for signing, such as:

> "I just think it's the right thing to do."
>
> "To help keep the cost down in our neighborhood so people could seek medical help."

Most physicians mentioning altruistic reasons also indicated that the advantage to their patients was an important specified reason.

External pressure was often mentioned as a reason:

> "That's the way the hospital collects and that's the way we had to do it."
>
> "The group as a whole made the decision."

Other physicians mentioned the opportunity to receive direct payment from the government as a factor in their decision, including:

> "... so that Medicare patients wouldn't be able to keep the checks."
>
> "To get a check from the government for the patients."

Physicians often felt they did not have a choice or, more specifically, they were pressured under the Massachusetts law. These reasons were mentioned more frequently by physicians who changed from non-signers to signers than by those who signed throughout. Physicians that felt they did not have a choice seemed concerned about the sanctions for non-participants. For example,

> "So many problems if I didn't sign."
>
> "Government had foot on our necks."

In Massachusetts, physicians are prohibited from balance billing under a state law enacted in April 1986. As a result, some physicians felt forced to sign:

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*Refer to Section 2.3 and Appendix A for details on the coding of open-ended questions.

"In Massachusetts I think you have to sign according to law."

"...Massachusetts does not allow balance billing...it makes sense to participate."

Indeed, Massachusetts physicians do have participation rates that are about twice the average in all four time periods. Burney and Paradise (1987) calculate weighted participation rates for Massachusetts physicians that rise from 71 percent in October 1984 to nearly 86 percent in January 1987. (The weighted assignment rate for the first quarter of 1987 was 98 percent.)

Table 3-6 presents the importance of specified reasons for physicians not signing the participation agreement. The top panel indicates the reasons for physicians who did not sign the agreement in any of the first three time periods. Nearly all non-signing physicians (94 percent) believe that physicians should set their own fees. Furthermore, most non-signers (78 percent) felt the ability to balance bill patients was an important reason not to sign and 82 percent of non-signers felt there was no advantage to signing. Non-signers were fairly consistent in agreeing on two factors that were <u>not</u> important, namely colleagues' decision not to sign and small Medicare caseloads.

The bottom panel of Table 3-6 presents the importance of specified reasons behind physicians' decisions to change from signers to non-signers. Clearly, the most important reason was the perceived government double cross when the fee freeze was extended (reported by three-fourths of physicians in this group). Also, this group of physicians preferred to leave open the option of balance billing some patients who could afford to pay the full fee. Some physicians may have signed in October 1984 in anticipation of reduced paperwork or administrative burden. Two-thirds indicated that their expectations were not met in this regard. This group apparently did <u>not</u> change their decision as a result of unmet expectations with respect to their Medicare patient load -- only 25 percent indicated their patient load did not increase as much as anticipated.

Fifty-five percent of non-signers throughout and 32 percent of signers to non-signers mentioned other very important reasons for not signing the participation agreement. The most frequently mentioned reason was <u>philosophical opposition</u>. Often these responses were the result of physicians venting their anger with the terms of the agreement or with the government, as illustrated by the following two responses:

"I hate the federal government -- once you sign you are in a bind."

"I don't believe there should be interference with the contract between a patient and doctor."

TABLE 3-6

REASONS FOR NOT SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY LEVEL OF IMPORTANCE

	Very Important	Somewhat Important	Not Important
Non-Signers Throughout			
Colleagues decided not to sign	14.8%	23.1%	62.2%
Few Medicare patients	9.3	14.5	76.2
Want to balance bill patients	50.7	27.7	21.6
Believe physicians should set own fees	77.9	16.4	5.7
No advantage to signing	59.4	22.6	18.0
Signers to Non-Signers			
Patient load didn't increase as much as anticipated	7.0%	17.9%	75.1%
Didn't reduce paperwork or administrative burden	38.4	27.4	34.2
Want to balance bill patients	46.7	26.0	27.3
Fee freeze extended beyond original date	54.3	21.0	24.7

Source: 1987 Physicians' Practice Follow-up Survey.

Other physicians were concerned with low payment rates:

> "[Agreement] was not realistic in keeping up with the rising costs of running a practice."
>
> "Because I have a very low profile and my income will drop if I accepted assignment."
>
> "I got less pay from Medicare after I signed up."

Physicians also complained about the administrative burden. Signers to non-signers were twice as likely as non-signers throughout to mention this as a reason. Two physicians complained:

> "Payback from government [is] too hard to get back."
>
> "Red tape - more forms to deal with."

Physicians mentioned their objection to mandatory assignment as an additional reason, although this clearly overlaps with two of the specified reasons (i.e., want to be able to balance bill patients, physicians should set their own fees). Among the responses:

1 "I would rather make the decision on giving poor people a discount."

2 "Many patients can afford and are happy to pay the balance."

Several physicians who changed from signers to non-signers, felt that the government did not follow up on its promise. They felt that the government "double-crossed" physicians when the fee freeze was extended in fiscal year 1986:

> "Congress promised a pay increase and nothing happened."
>
> "Basically the federal government didn't keep their end of the bargain."

Less than one percent of physicians changed their decision in each of the first three time periods. All were signers initially, then non-signers in October 1985, and once again signers in May 1986. This group was asked an open-ended question on their reasons for changing in all three time periods. Because of the small number of physicians in this group and problems in interpreting some of their remarks, it was not possible to develop a coding scheme for this group. Some physicians, for example, gave the rationale for the most recent decision or for two of the three decisions. However, two threads run through their remarks. In several cases, the physician indicated

the decision was out of his or her control. For example, one physician said "for partnership reasons," while another said "I was a part of [a] faculty practice so there was no other choice."

In several other cases, physicians seemed to indicate that their expectations were not met so they decided not to sign, but then for one reason or another felt forced to sign again. The following three remarks illustrate this pattern:

- "That's difficult since there have been so many signings of so many agreements for different health organizations. We were trying to make it convenient for patients. I can't remember reason why we went off and on. Medicare kept changing their minds on what they were going to do. We were being bombarded with flyers and horror stories. We went back on when Medicare straightened out."

- "I first signed so my patients wouldn't have to go to another doctor who was participating. They said we would be rewarded for participating but Medicare played us for suckers -- they didn't reward us, so I dropped it. I signed up again for the benefit of my patients, and because I couldn't fight this thing alone."

- "Because they didn't pay right, they didn't pay enough and I got mad and didn't participate the next time and then we didn't have many Medicare patients anyway. And then we tried to get some information from them because they weren't paying and they said we couldn't get the information because we were not signed up. So we decided to participate again -- it was easier."

3.4 January 1987 Decision

The Omnibus Budget Reconciliation Act of 1986 (OBRA) created a complex array of incentives for physicians to sign the participation agreement in January 1987. These incentives and penalties were believed to be of more substance than those for previous sign-up periods. First, the update in the prevailing charge levels for non-participants was only 96 percent of the prevailing charge for participants. Second, non-participants have been limited in their actual charge levels (known as the maximum allowable actual charge), based on a formula that compares the lower of (1) the physicians' 1984 base-period charge or (2) the 1986 average actual charge, to the 1987 prevailing charge for non-participating physicians. The actual charge limits are calculated for each procedure or service the physicians performs. Beginning October 1, 1987, non-participants must notify beneficiaries of the estimated actual charge for elective surgery of $500 or more; the estimated approved charge; the amount by which the actual charge exceeds the approved

charge; and the amount of coinsurance. This provision is designed to provide the beneficiary with sufficient information on potential liability for elective surgical procedures.

Other participation incentives include prompter payment of participants' claims; listing in a directory of participating physicians; notices about the participation program to beneficiaries submitting unassigned claims; requirement of hospital officials to inform patients of physician participation status when making hospital referrals and to identify a participating physician, where possible; toll-free telephone lines maintained by the carriers to provide names of participating physicians; and emblems of participation to display in the physician's office.

Despite these incentives, there were no dramatic changes in the participation rates between the May 1986 and the January 1987 sign-up periods (recall Table 3-1). The overall participation rate was 38.6 percent, a 2.5 percentage point increase from May 1986. Only one specialty -- obstetrics/gynecology -- experienced a large (but non-significant) increase over the four time periods, ranging from 35.6 percent in October 1984 to 45.0 percent in January 1987.

Table 3-7 shows the relationship between previous decisions and the January 1987 decision. Nearly all of the physicians who signed throughout the other three time periods also signed in January 1987 (96 percent). Similarly, virtually all physicians (93 percent) who did not sign throughout the three periods, also did not sign in January 1987. This same pattern is evidenced among physicians who changed their decision in an earlier time period: 92 percent of physicians who had changed from signers to non-signers during the first three periods remained non-signers, and 91 percent of non-signers to signers remained signers in January 1987. These data seem to indicate that the incentives introduced with the January 1987 sign-up did not influence many physicians to change their decision regarding the participation agreement. Another factor that may have deterred some physicians from signing in January 1987 was confusion surrounding a lawsuit testing the constitutionality of the participation program. The suit was filed shortly before the sign-up period was scheduled to end.

Physicians that did change their decision between May 1986 and January 1987 were asked what factors motivated their change. Physicians changing from non-signers to signers in January 1987 (5 percent of all physicians) most often cited the <u>reduced administrative burden</u>, such as improved collections, less paperwork, and the opportunity to receive direct payment from the government. Illustrating this is one physician's response: "Most of the patients did not want to pay my bills after they got their money." Physicians also reported that they <u>felt forced by the government</u>. One physician noted,

TABLE 3-7

RELATIONSHIP BETWEEN PREVIOUS PARTICIPATION DECISIONS AND THE JANUARY 1987 DECISION[a]

	JANUARY 1987 DECISION	
Previous Decisions	Percent Signers	Percent Non-Signers
Signer throughout	96.3%	3.7%
Non-signer throughout	7.1	92.9
Signer to non-signer	7.9	92.1
Non-signer to signer	91.4	8.7
Signer/non-signer/signer	96.5	3.5

[a]Rows sum to 100 percent.

Source: 1987 Physicians' Practice Follow-up Survey.

"I felt that in a couple of years we were going to be forced anyway." Another indicated, "I felt the government was going to invade my practice so I better sign now before they do."

The third most important factor was the sense that there was too much to lose by not signing. Some physicians expressed confusion about the terms of the January 1987 agreement, while others simply wanted to be eligible for the new benefits. For example, one physician mentioned, "I had to sign to get the benefits," while another stated, "The new law concerning Medicare patients was too confusing and the penalties for not understanding the law are crucial."

Competition played a role in some physicians' decisions to sign in order to maintain or increase patient load. The following remarks illustrate physicians' concerns about the competitive environment:

- "Forcing hospital to tell patients to pick participating doctors and I don't want to lose patients."
- "I had a lot of patients complaining about me not signing."
- "The group changed their minds mostly on the probability of balancing payments and competition."

Patients are likely to be more knowledgable about the participation program now versus several years ago and influence physicians to sign in an increasingly competitive environment. In addition, some physicians stated more altruistic motives, and decided to sign as a service to patients (although the same economic incentives may be underlying their decision). One physician replied, "I did it out of consideration of my patients. They didn't understand the change; they were confused. It was more convenient for them."

Physicians changing from signers in May 1986 to non-signers in January 1987 (2 percent of all physicians) were frequently motivated by a concern over low or unpredictable payments. One physician, for example, changed "because Medicare told me that I was going to get a certain amount and I did not receive what was promised. Each time they reimburse you, you have no idea what you are going to get back." Another frequent factor was a change in practice situation, usually causing a change in decision that was beyond the physician's control. Some physicians had retired by January 1987 (although they remained eligible for the survey because they practiced for at least half of 1986); others left private practice between May 1986 and January 1987. Finally, some physicians expressed a strong anti-government sentiment:

- "Physicians are losing their freedom and rights to charge patients. The government has lied to us."
- "They did not lift the fee freeze as they said they would."
- "The law is unconstitutional. I don't appreciate them fixing my fees."

4.0 TRENDS IN MEDICARE ASSIGNMENT RATES, 1985-1987

The imposition of the Medicare Participation program as of October 1, 1984 (FY 1985) led to a dramatic increase in assignment rates in just one year--rising from 57.9 percent in FY 1984 to 67.4 percent in FY 1985 (Burney and Paradise, 1987). These rates are based on the "percentage of total covered charges attributable to assigned claims for services billed by both physicians and non-physicians." Assignment rates have continued to increase, although at a slower pace. During the first quarter of 1987, an estimated 70.0 percent of total covered charges were assigned. For physician charges alone, assignment rates rose from 65.5 percent in FY 1985 to 67.2 percent in the first quarter of 1987, a 2.6 percent increase.

This section compares the assignment rates reported by physicians participating in both the initial PPCIS and the Follow-up Survey. We begin with a description of our method, followed by a comparison by specialty and by decision pattern.

4.1 Method

Both the initial PPCIS and the Follow-up Survey asked non-participating physicians what percent of their current Medicare caseload is accepted on assignment. Participating physicians, by definition, accept 100 percent of their Medicare cases on assignment. We compared assignment rates of physicians who participated in both the initial PPCIS and the Follow-up Survey. The sample is limited to physicians who were self-employed at the time of the initial interview because the PPCIS asked only self-employed physicians with any Medicare patients about their assignment rate.

Mean assignment rates were computed based on physicians reporting data in both time periods and then a percentage change is calculated based on the means. We assumed that physicians who signed the participation agreement in October 1984 had a 1985 assignment rate of 100 percent and similarly, that signers in January 1987 had an assignment rate of 100 percent.

We offer several qualifications related to this analysis. First, the assignment rate is neither weighted by amount of Medicare charges nor by number of Medicare patients or visits. This introduces obvious distortions. Take, for example, one non-participating physician with 100 Medicare patients and a 20 percent assignment rate, compared to another with 25 Medicare patients and an 80 percent assignment rate. In this simple example, they each accept 20 patients on assignment but their assignment rates are quite different. Second, the time frame for the assignment rate data corresponds to the date of interview which spanned November 1984 to June 1985 (initial PPCIS)

and January to June 1987 (Follow-up Survey). Most interviews for the Follow-up Survey occurred during February and March 1987. In relation to the estimates by Burney and Paradise, this time frame corresponds to FY 1985 and first quarter 1987 figures. Third, the survey asked for a single assignment rate covering all types of services (e.g., hospital, office, surgery, and outpatient). A small number of physicians were unable to provide an assignment rate covering all types of services. To the extent that there are inconsistencies over time, the comparison may include some data that are not comparable for the two reporting periods.

4.2 Assignment Rates by Specialty

The average assignment rate rose about 2 percent from 1985 to 1987, from a base of 53.0 percent to 53.9 percent (Table 4-1). (This difference, however, is nonsignificant at the 0.05 level.) Both the rate of increase and the absolute rates are lower than those reported by Burney and Paradise (1987) because they are not weighted on the basis of charges. Not only are more expensive services more likely to be accepted on assignment (e.g., surgeries), but also physicians with larger Medicare caseloads are more likely to sign the participation agreement.*

Historically, surgeons have had the highest assignment rates. This continues to be the case and furthermore, surgeons in three specialties experienced the largest growth in assignment rates from 1985 to 1987, although none of the differences were found to be significant.** In particular, assignment rates among ophthalmologists rose from 47 percent to 53 percent, a gain of 12 percent. Urologists had a 10 percent increase from 54 to 60 percent. The relatively high rate of increase among obstetrician/gynecologists reflects their increasing participation rates from 36 percent to 45 percent across the four participation periods (discussed in chapter 3.0).

Anesthesiologists have had historically low assignment rates and radiologists have had historically high rates. The relative levels remained the same, with the two groups experiencing 3.8 and 3.2 percent increases, respectively.

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*Refer to Mitchell, Rosenbach, and Cromwell (1987) for a discussion of factors associated with signing the participation agreement in October 1984.

**Specifically, we performed t-tests comparing the mean assignment rate in 1985 versus 1987, within specialty. None of the intraspecialty comparisons were significant at the 0.05 level.

TABLE 4-1

ASSIGNMENT RATES BY SPECIALTY, 1985-1987[a]

	Mean Assignment Rate		
	1985	1987	Percent Change
All physicians	**53.0%**	**53.9%**	**1.8%**
General practice	45.7	40.4	-11.6
Family practice	51.5	51.4	-0.1
Internal medicine	40.7	40.3	-0.9
Cardiology	61.3	64.9	5.8
Other medical specialties	58.0	58.7	1.2
General surgery	63.9	65.1	1.8
Orthopedic surgery	56.5	58.3	3.1
Ophthalmology	47.3	53.1	12.2
Urology	54.2	59.6	9.8
Obstetrics/gynecology	60.2	64.7	7.5
Other surgical specialties	57.3	56.9	-0.7
Anesthesiology	38.6	40.0	3.8
Radiology	67.2	69.3	3.2

[a]These assignment rates represent the percent of the physician's Medicare caseload accepted on assignment. Mean assignment rates were compared within specialty and some of the differences between 1985 and 1987 were found to be significant at the 0.05 level.

Source: 1987 Physicians' Practice Follow-up Survey.

Four specialties averaged lower assignment rates in 1987 compared to 1985, although none of the differences were significant. Three specialties showed less than a 1 percent reduction (family practice, internal medicine, and other surgical specialties), while general practitioners had a 12 percent decline (from 46 percent to 40 percent). In part this may be a function of an above average level of general practitioners changing from signers to non-signers: whereas 6.5 percent of all physicians changed from signers to non-signers, 10.4 percent of general practitioners did so.

4.3 Assignment Rates by Decision Pattern

Table 4-2 compares assignment rates according to the five participation decision patterns discussed in chapter 3.0. By definition, physicians who participated throughout (30 percent of all physicians) had assignment rates of 100 percent in both 1985 and 1987, as did those who changed from signers to non-signers and then signed again. Physicians who refused to sign the participation agreement have significantly increased their assignment rates, from 24 percent (1985) to nearly 30 percent (1987), a 24 percent gain. Because, the largest gains took place within the surgical specialties (particularly ophthalmology) it is likely that an even larger gain would be evidenced if these rates were weighted on the basis of charges.

A 72 percent reduction in assignment rates was found for those switching from signers to non-signers. Initially accepting all cases on assignment, their assignment rate fell to 28.5 percent, roughly the same level as physicians who refused to sign throughout. Physicians who changed from non-signers to signers had an assignment rate nearly twice as high as other non-signers in 1985 (44.5 percent), and by signing the participation agreement in January 1987 their assignment rate rose to 100 percent (126 percent gain). Undoubtedly, the higher 1985 assignment rate of this group (compared to non-signers throughout) predisposed them to signing in January 1987.

TABLE 4-2

ASSIGNMENT RATES BY DECISION PATTERN, 1985-1987[a]

	Percent of physicians	Mean Assignment Rate[b] 1985	1987	Percent Change
All Physicians	**100.0%**	**53.0**	**53.9**	**1.8**
Signer throughout	29.9%	100.0%	100.0%	0.0%
Non-signer throughout	57.4	23.9	29.7[c]	24.1
Signer to non-signer	6.5	100.0	28.5[c]	-71.5
Non-signer to signer	5.6	44.5	100.0[c]	125.7
Signer/non-signer/signer	0.7	100.0	100.0	0.0

[a]Refer to Chapter 2.0 for details on classification by decision pattern.

[b]These assignment rates represent the percent of the physician's Medicare caseload accepted on assignment.

[c]Assignment rates for 1985 and 1987 are significantly different at 0.05 level.

Source: 1987 Physicians' Practice Follow-up Survey.

5.0 WHO ARE THE DE FACTO PARTICIPANTS?

Non-participating physicians can be differentiated by their level of assignment: the zero-assigners, occasional assigners, and de facto "participants." The de facto "participants" accept all Medicare cases on assignment. Although their assignment behavior is the same as actual participants, they receive none of the benefits that accrue with participation. Who are the de facto participants and why do they choose not to sign the Participation Agreement?

This section compares de facto participants to other non-participants, as well as to actual participants, with respect to specialty mix and Medicare dependence. Also, their reasons for not signing the Participation Agreement are examined.

5.1 Characteristics of De Facto Participants

The designation of de facto participation is based on non-participation in all four sign-up periods and a current assignment rate of 100 percent (reported as of the time of interview). Altogether, 69 physicians in our sample are considered de facto participants based on these criteria.

About 6 percent of non-participating physicians are de facto participants, while 19 percent are zero-assigners (see Table 5-1). Following the October 1984 participation decision, we estimated a de facto participation rate of 6 percent, based on the initial Physicians' Practice Costs and Income Survey (Rosenbach, Hurdle, and Cromwell, 1985). It should be noted, however, that two specialties with disproportionately high de facto participation rates -- psychiatry and pathology -- have been excluded from the 1987 Physicians' Practice Follow-up Survey. Among the de facto participants in October 1984, more than half were no longer accepting all cases on assignment in 1987. Conversely, of the de facto participants in 1987, four-fifths were "occasional assigners" in 1984.

Due to the small sample size for de facto participants, it is not possible to examine a detailed specialty mix of the three groups of non-participants. Instead, the physicians have been classified in four specialty groups. Surgical specialists are disproportionately represented among de facto participants (47 percent), compared to the zero assigners (40 percent) and occasional assigners (36 percent). In part, this finding may reflect some surgeons' practices of accepting all hospital-based care on assignment but selectively balance billing for office-based services. Unfortunately, we are unable to distinguish this practice from true de facto participation. General and family practitioners account for a higher share of

TABLE 5-1

EXTENT OF ASSIGNMENT BY SPECIALTY GROUP AND MEDICARE DEPENDENCE[a]

	De facto Participants	Occasional Assigners	Zero-Assigners
Percent of Non-Participants[b]	6.1%	75.5%	18.5%
Specialty Group[c]			
GP/FP	22.9%	20.7%	32.9%
Medical	21.4	31.2	13.1
Surgical	47.1	36.1	40.4
Other	8.6	12.1	13.6
Medicare Dependence[c]			
1 - 10 percent	41.7%	14.3%	36.4%
11 - 20 percent	17.4	15.4	22.9
21 - 30 percent	9.4	20.6	12.1
31 - 40 percent	13.6	15.9	8.4
41 - 60 percent	12.8	23.3	13.2
More than 60 percent	5.2	10.5	7.1
Average Percent	23.4%	35.6%	24.7%

[a]De facto participants accept all cases on assignment; occasional assigners accept 1 to 99 percent on assignment; and zero assigners accept no cases on assignment.

[b]Row sums to 100 percent.

[c]Columns sum to 100 percent.

Source: 1987 Physicians' Practice Follow-up Survey

zero-assigners probably due to their concern over the low amounts paid for non-procedural services (e.g., visits versus surgery). Finally, medical specialists represent a disproportionately large share of occasional assigners. These physicians are highly dependent on Medicare revenues and, thus, would be expected to accept assignment on some cases to accommodate patients unable to pay the physician's usual fee as well as to boost their Medicare patient load overall.

Medicare dependence, defined as the percent of caseload with Medicare Part B as primary payer, has the expected relationship with the extent of assignment. Those with small Medicare caseloads account for a much higher share of de facto participants (42 percent) and zero-assigners (36 percent). As Medicare dependence increases, non-participating physicians are increasingly more likely to accept some cases on assignment and correspondingly less likely to be de facto participants or zero assigners. This result is not surprising. As Medicare dependence rises, the likelihood of treating a Medicare patient who cannot pay the balance between allowable and actual charges increases by chance alone; hence the negative relationship between zero-assignment and Medicare dependence. Similarly, as Medicare dependence increases, de facto participation declines given the greater probability of balance billing some wealthier patients.

5.2 De Facto Participants' Reasons for Not Signing the Participation Agreement

If the assignment behavior of de facto participants mirrors that of actual participants, why then have de facto participants consistently chosen not to sign the Participation Agreement? By far the most common reason reported -- regardless of the extent of assignment -- was a philosophical belief that physicians should set their own fees rather than accept what the government pays as payment in full (Table 5-2). Although three-fourths of de facto participants indicated this was a very important factor in their decision not to sign, it would appear to contradict their practice of accepting all cases on assignment. Similarly, almost a third of de facto participants stated a desire to balance bill patients which, too, seems contradictory if they in fact accept all cases on assignment. Three explanations are possible. First, de facto participants may be expressing a strong philosophical opposition to mandatory assignment together with a preference for keeping their billing options open. Second, some de facto participants may overstate slightly their current assignment rate. Instead of reporting, say, a 99 percent assignment rate, "rounding error" results in

TABLE 5-2

REASONS FOR NOT SIGNING THE MEDICARE PARTICIPATION AGREEMENT BY EXTENT OF ASSIGNMENT (Percent stating reason was very important)

	De facto Participants	Occasional Assigners	Zero-Assigners
Believe physicians should set their own fees	73.2%	78.6%	83.4%
No advantage to signing	47.7	61.0	65.1
Want to balance bill patients	29.8	52.3	54.4
Colleagues decided not to sign	11.0	12.2	18.1
Few Medicare patients	17.7	6.8	16.9

Source: 1987 Physicians' Practice Follow-up Survey.

their classification as a de facto participant. Third, some physicians may accept all hospital-based services on assignment, and selectively balance bill patients for office-based care. This, too, would tend to overstate the extent of de facto participation.

De facto participants were less likely than the other two groups to report there was no advantage to signing. This is surprising in view of their assignment behavior. One explanation may be that they have few Medicare patients. Both the de facto participants and the zero assigners were more likely than the occasional signers to cite their small Medicare caseloads as an important reason for not signing (recall from Table 5-1 that occasional assigners have a relatively larger Medicare caseload than the other two groups). Also, colleagues seem to influence de facto participants less than zero assigners, in particular.

In general, what seems to be dominating the de facto participants' motivation for not signing is a philosophical opposition to the terms of the participation agreement. Not only do de facto participants cite seemingly contradictory reasons for not signing (i.e., want to balance bill patients, believe physicians should set their own fees), but when asked to specify other important reasons for not signing, one-third of the de facto participants (compared to one-fourth of the other two groups) cited a variety of philosophical reasons such as "opposition to government intrusion in medical practice" or "interferes with the physician/patient relationship."

5.3 Comparison of Actual and De Facto Participants

Table 5-3 compares actual and de facto participants in terms of their specialty mix and Medicare dependence. By actual participants, we mean physicians who signed the participation agreement in all four time periods. As defined earlier, de facto participants did not sign in all four time periods and reported a current assignment rate of 100 percent. The distribution by specialty group indicates that medical specialists account for a higher proportion of the actual participants (32 percent), than of the de facto participants (21 percent), while surgical specialists account for a higher share of de facto participants (47 percent) than actual participants (39 percent). This suggests that surgical specialists prefer to keep their options open by not signing the agreement. General and family practitioners also appear to be disproportionately represented among de facto participants.

Physicians with a small Medicare caseload account for a very large proportion of the de facto participants. Over 40 percent of the de facto participants (but only 17 percent of actual participants) reported that Medicare cases were 10 percent or less of their patient load. In contrast,

TABLE 5-3

COMPARISON OF ACTUAL AND DE FACTO PARTICIPANTS, BY SPECIALTY GROUP AND MEDICARE DEPENDENCE

	"Actual" Participants[a]	"De Facto" Participants[b]
Specialty Group		
GP/FP	13.7%	22.9%
Medical	31.8	21.4
Surgical	39.1	47.1
Other	15.3	8.6
Medicare Dependence		
1 - 10 percent	16.5%	41.7%
11 - 20 percent	15.2	17.4
21 - 30 percent	16.8	9.4
31 - 40 percent	17.0	13.6
41 - 60 percent	18.1	12.8
More than 60 percent	16.4	5.2
Average Percent	36.6%	23.4%

[a]Includes physicians who signed the Medicare participation agreement in all four time periods.

[b]Includes physicians who did not sign the Medicare participation agreement in all four time periods and who reported a current assignment rate of 100 percent.

Source: 1987 Physicians' Practice Follow-up Survey.

those with large Medicare caseloads (over 30 percent) accounted for a larger share of those who signed the agreement (52 percent) versus the de facto participants (32 percent). Physicians with a relatively small Medicare caseload may decide that is is not worth their effort to sign (even though they accept all cases on assignment), whereas those with large Medicare caseloads may recognize the economic advantages to signing, such as maintaining current Medicare patients, attracting new Medicare patients, and receiving differential fee updates and payment levels for participants versus non-participants.

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APPENDIX A

VERBATIM RESPONSE CODES FOR OPEN-ENDED QUESTIONS

TABLE A-1

VERBATIM RESPONSE CODES FOR SIGNERS THROUGHOUT

- Direct Payment (Physician wanted to bill Medicare directly to avoid collection problems)

  "...patients would use the money for other purposes"

  "Easy collectability of the fees"

  "To get the money"

- Altruism (Signed to help patients or government; cited quality of care concerns or general philosophical reasons)

  "I just think it's the right thing to do"

  "To take care of patients who need care"

  "To help keep the cost down in our neighborhood so people could seek medical help"

  "Somebody has to take care of these patients"

- External Pressures or Suggestions (Group decision; employer's decision; practice policy; suggested by financial advisor)

  "That's the way the hospital collects and that's the way we had to do it"

  "The group as a whole made the decision"

  "Practice of emergency medicine does not permit you to refuse patients"

  "In this area it was universal agreement for the doctors in my field to sign"

  "I have an office consultant who suggested it"

  "Our management consultant said it was financialy advantageous"

- Confusion About Program (Didn't mean to sign; thought that signing was required; didn't understand agreement)

  "Didn't understand what was going on..."

- No Particular Disadvantage (Didn't have many Medicare patients; no economic disadvantage)

  "Fee freeze didn't hurt me the way it would a surgeon or specialist -- it wasn't that big a burden"

  "We don't lose anything from signing"

  "I had hardly any Medicare patients"

TABLE A-1 (continued)

VERBATIM RESPONSE CODES FOR SIGNERS THROUGHOUT

- To Maintain Caseload (Trying to maintain competitiveness; didn't want to lose referrals or patients)

  "...surrounding hospitals are going to participate and I didn't want to lose patients"

  "People that referred me cases had signed so I felt that I had to sign or they wouldn't send me the patients"

  "Most of my patients are Medicare; I'm a nephrologist"

- Patients Can't Afford Full Charge

  "Patients can't afford to pay anyway"

  "I live in an economically depressed area and most patients couldn't pay their fees"

- Didn't Have A Choice (Felt forced, didn't want to be sanctioned)

  "We were threated with jail if we changed a fee and didn't sign"

  "So many problems if I didn't sign"

  "Didn't want to fall under penalty..."

  "Government had foot on our necks"

- Pressured under Massachusetts Law (Either felt forced to sign, or makes sense to sign since Massachusetts does not allow balance billing)

  "The state of Massachusetts does not allow balance billing...it makes sense to participate"

  "It is state law for doctors to sign the PPA in Massachusetts"

  "In Massachusetts I think you have to sign according to law"

- Other/Uncodeable (Uncodeable, incomplete responses; vague responses; all other responses)

  "We weighed pros and cons and decided to sign"

  "It was economically beneficial to the practice"

  "The less hassle the better"

  "Too much of a hassle to stay out, just easier to participate"

  "We all participated"

  "Our charges are lower, so we come out ahead"

TABLE A-2

VERBATIM RESPONSE CODES FOR NON-SIGNERS THROUGHOUT

- Administrative Burden (Paperwork; slow payments; no payments; bureaucracy)

  "Red tape - more forms to deal with"

  "I had experience with Medicare in which they delayed payments..."

  "Payback from goverment too hard to get back"

- Program is Unfair (Variation in rates due to location or specialty; HCFA doesn't follow up on promises)

  "...reimbursement for surgical procedures is much overvalued as compared to cognitive services"

  "I think it's patently unfair"

  "The government reneged in the past so there's no advantage to signing"

  "Method rewards high charging physicians and penalizes physicians with less charges"

- External Requirements (Group decision; employer decided)

  "I changed my decision on recommendation of my partners, not colleagues"

  "The corporation determines the billing policy"

- Low Rates (Payment doesn't cover costs; payment too low to maintain adequate quality of care; can't raise fees)

  "[Agreement] was not realistic in keeping up with the rising cost of running a practice"

  "...financially we would come out better by not taking assignment"

  "Because I have a very low profile and my income will drop if I accepted assignment"

  "To cover my overhead costs, I would have to cost-shift to non-Medicare patients"

- Philosophical Opposition (Opposed to governmental or third party intervention; felt forced; wants to maintain independence)

  "I don't believe there should be interference with the contract between a patient and doctor"

  "I don't like being told what to do by the government"

  "Basically we think that when you go into business with the government, it is like sleeping with a cobra"

TABLE A-2 (continued)

VERBATIM RESPONSE CODES FOR NON-SIGNERS THROUGHOUT

- Confusion/Uncertainty (Agreement too confusing; couldn't understand; not certain of impact on practice)

  "Don't understand it - it was too complex"

  "Not knowing what the effect would be and not being able to back out of it..."

- Objects to Mandatory Assignment (Wealthy patients should pay full charge; doesn't want to assign all patients; physician and/or patient should decide who needs assignment)

  "I would rather make the decision on giving poor people a discount"

  "If patient has a secondary insurance that covers everything, you never see that money...it's a boon for the insurance companies"

- Other/Uncodeable (All other responses; incomplete or incoherent responses)

  "I didn't want the publicity of signing"

  "We believe it's too restrictive and very likely to change anyway"

TABLE A-3

VERBATIM RESPONSE CODES FOR SIGNERS TO NON-SIGNERS

- Administrative Burden (Paperwork; slow payments; no payments; bureaucracy)

  "Increased employee hours for the paperwork and the difficulty in the appeal system... if the claim was denied we had to start all over again with the paperwork"

  "Too much hassle calling for approval and explaining diagnoses"

- Program is Unfair (Variation in rates due to location or specialty; HCFA doesn't follow up on promises)

  "I thought the entire agreement was unfair..."

  "Unfair system - too much rigidity..."

  "My specialty gets exceedingly low reimbursements"

- External Requirements (Group decision; employer decided)

  "The place that I was employed didn't [take patients on assignment]"

  "The corporation determines the billing policy"

- Low Rates (Payment doesn't cover costs; payment too low to maintain adequate quality of care; can't raise fees)

  "I got less pay from Medicare after I signed up"

  "Lost lots of money"

  "The reduction in allowable charges subsequent to my signing"

- Philosophical Opposition (Opposed to governmental or third-party intervention; felt forced; wants to maintain independence)

  "I hate the federal government -- once you sign you are in a bind"

  "I am a person who loves personal freedom"

- Confusion/Uncertainty (Agreement too confusing; couldn't understand; not certain of impact on practice)

  "It was confusing -- hard to understand"

  "Harrassment and failure to understand what in the world they wanted me to do"

TABLE A-3 (continued)

VERBATIM RESPONSE CODES FOR SIGNERS TO NON-SIGNERS

- Objects to Mandatory Assignment (Wealthy patients should pay full charge; doesn't want to assign all patients; physician and/or patient should decide who needs assignment)

  "Do not like government telling me who I can see (patients) -- do not like splitting fees"

  "Many patients can afford and are happy to pay the balance"

- Government Didn't Follow Up On Promises (fees weren't increased; government lied)

  "Congress promised a pay increase and nothing happened"

  "Basically the federal government didn't keep their end of the bargain. At one point they wanted us to sign an open-ended contract"

  "Medicare lied to us about the agreement"

- Other/Uncodeable (All other responses; incomplete or incoherent responses)

  "Many Medicare patients didn't like it"

TABLE A-4

VERBATIM RESPONSE CODES FOR NON-SIGNERS TO SIGNERS

- Direct Payment (Physician wanted to bill Medicare directly to avoid collection problems)

  "So that Medicare patients wouldn't be able to keep the checks"

  "To get a check from the government for the patients"

- Altruism (Signed to help patients or government; cited quality of care concerns or general philosophical reasons)

  "Mostly it was to help out my patients so they wouldn't have to pay the balance"

  "We felt sorry for the poor older folks"

  "[To] make sure Medicare patients got care..."

- External Pressures or Suggestions (Group decision; employer's decision; practice policy; suggested by financial advisor)

  "My partners all did it"

- Confusion About Program (Didn't mean to sign; thought that signing was required; didn't understand agreement)

  "I signed by mistake..."

- No Particular Disadvantage (Didn't have many Medicare patients; no economic disadvantage)

  "The fact that I have so few Medicare patients, so I can afford to give them care when they need it"

- To Maintain Caseload (Trying to maintain competitiveness; didn't want to lose referrals or patients)

  "Most of the doctors were doing it and we were losing some of our patients"

- Patients Can't Afford Full Charge

  "I had a lot of patients on Medicare who couldn't pay"

- Didn't Have A Choice (Felt forced, didn't want to be sanctioned)

  "They sent me a letter saying I would be sent to jail or fired for raising my fee for an x-ray, so I thought if I signed, this wouldn't happen"

  "The government almost forced us to sign -- I wanted to protect my image"

TABLE A-4 (continued)

VERBATIM RESPONSE CODES FOR NON-SIGNERS TO SIGNERS

- Massachusetts Law Forbids Balance Billing (Either felt forced to sign, or makes sense to sign since Massachusetts does not allow balance billing)

  "..we were forced to sign by state law"

- Other/Uncodeable (Vague or incomplete responses; all other responses)

  "We were grossly undercharging for our services and so we signed so we could change our [charge] profile..."

TABLE A-5

VERBATIM RESPONSE CODES FOR PHYSICIANS WHO CHANGED FROM MAY 1986 to JANUARY 1987

A. NON-SIGNERS TO SIGNERS

- Felt Forced By Government

  "I felt that in a couple of years we were going to be forced anyway"

  "The fact of the government saying you should sign"

  "I felt the government was going to invade in my practice so I better sign now before they do"

- Reduced Administrative Burden (improved collections, less paperwork, direct payment)

  "Most of the patients did not want to pay my bills after they got their money"

  "Can be assured of direct payment now that I have signed"

  "They have less paperwork"

- MAAC Too Confusing

  "The hopeless confusion with respect to Maximum Allowable Charges"

- Wanted To Update Fees

  "I was frozen in fees below what Medicare was allowing"

  "I could raise my fees more if I signed than if I hadn't"

- To Avoid The Four Percent Fee Differential Between Participants And Non-participants

  "Government would have cut my payment by 4 percent"

  "I was sort of forced to sign because they said there would be a 4 percent reduction in Medicare payments to physicians who didn't sign"

- Too Much To Lose By Not Signing

  "With the new assignment agreement the government made it too complicated not to sign. They imposed set of rules for nonparticipating doctors that participating doctors were excused from"

  "Because they made it so difficult for us if we did not participate"

TABLE A-5 (continued)

VERBATIM RESPONSE CODES FOR PHYSICIANS WHO CHANGED FROM MAY 1986 to JANUARY 1987

"The new law concerning Medicare patients was too confusing and the penalties for not understanding the law are crucial"

"New legislation put further restrictions on fees"

"Because I had to sign to get the benefits"

"Changes in law make it difficult for doctors that didn't sign. We do have a laboratory and wanted to continue using it. We couldn't do it if we didn't sign"

- Suggested by Financial Advisor (bookkeeper, accountant, office manager)

  "On the advice of my bookkeeper"

  "I was advised by my accountant and business manager to do so"

- Suggested by Colleagues or Employer (partner, hospital, clinic)

  "The other doctors at the hospital who mostly decided to sign"

  "Because the company that I work for did it"

  "It was a department decision"

  "In January 1987 the Massachusetts Medical Society recommended that we sign and colleagues said 'be nice boys and sign up in 1987'"

- To Maintain or Increase Patient Load

  "Forcing hospital to tell patients to pick participating doctors and I don't want to lose new patients."

  "I had a lot of patients complaining about me not signing"

  "The group changed their minds mostly on the probability of balancing payments and competition"

- As a Service to Patients

  "Some of my patients couldn't afford the cost so I signed"

  "I did it out of consideration of my patients. They didn't understand the change; they were confused. It was more convenient for them"

- Change in Practice Situation

  "I changed location, opened a new practice, and the people in my location are older"

TABLE A-5 (continued)

VERBATIM RESPONSE CODES FOR PHYSICIANS WHO CHANGED FROM MAY 1986 to JANUARY 1987

- Other/Uncodeable

  "In August 1986 I picked up a nursing home; if you don't accept assignment on Medicaid patients, they won't pay you"

  "Not being able to charge the patient my normal fee for my services and not being able to bill the patient for the difference"

  "I don't really have any specific reasons for putting into effect"

B. SIGNERS TO NON-SIGNERS

- Payments Too Low or Unpredictable

  "Lack of payment"

  "Because Medicare told me that I was going to get a certain amount and I did not receive what was promised. Each time they reimburse you, you have no idea what you're going to get back"

- Outside Advice (partner, financial advisor)

  "One of my partners studied the situation and figured that it really didn't have any advantages and I just stuck to his decision"

- Change in Practice Situation

  "I'm no longer in practice treating Medicare patients; my fees are consultant fees now"

  "Not in private practice anymore"

  "I had retired by then"

- Government Double Cross/Anti-government

  "Physicians are losing their freedom and rights to charge patients. The government has lied to us -- my patients are happier now without all the billing hassles"

  "They did not lift the fee freeze as they said they would"

  "The law is unconstitutional. I don't appreciate them fixing my fees"

TABLE A-5 (continued)

VERBATIM RESPONSE CODES FOR PHYSICIANS WHO CHANGED FROM MAY 1986 to JANUARY 1987

- Administrative Burden (paperwork, slow payment)

  "I have too much paperwork to complete"

- Law was too Confusing

  "It was totally unclear what the new law entailed"

- Other/Uncodeable

  "I didn't forsee any advantage; the fees were no different"

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